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ABSTRACT

This report examines the incidence of drug abuse and the methods of treatment and prevention of drug abuse used in Southeast Asia. Countries studied include Malaysia, Singapore, Thailand, Indonesia, and the Philippines. Because of Malaysia's intensive effort to eliminate its drug abuse problem, emphasis is placed on this country's treatment and prevention system. The availability of heroin, opium, and cannabis in this part of the world is described and the seriousness of the drug problem in Malaysia is discussed. Data tables illustrate the number of drug abusers in the country and specific characteristics of abusers. The role of public education with respect to drug abuse prevention is described and activities of the governmental ministries are listed. Malaysia's comprehensive rehabilitation and treatment programs are presented and programs offered by prisons, governmental rehabilitation centers, and private agencies are described. Aftercare, required of all drug abusers, is discussed. A summary of drug abuse and treatment in Singapore, Thailand, Indonesia, and the Philippines is appended. (NB)

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DRUG ABUSE IN SOUTHEAST ASIA

Introduction

The purpose of this investigative study was to determine the incidence of drug abuse and the methods of treatment and prevention used in Southeast Asia. The countries which were studied included Malaysia, Singapore, Thailand, Indonesia and the Phillipines. Because of Malaysia's intensive effort to eliminate its drug abuse problem, emphasis was placed on this country's treatment and prevention system.

According to a 1982 report of the United Nations, drug abuse is the world's major health concern and has reached epidemic proportions in many parts of the world. This is clearly illustrated in the prevalence of drugs in Southeast Asia, where the problem of drug abuse presents a real danger to both the national security and economic stability of many of these developing nations. One major reason that this region is having a problem is due to the fact that it is the second largest producer of illegal opium, with a significant proportion being used internally. Specifically, the major drug producing areas in the world are the Golden Crescent and the Goldern Triangel. The largest producer, the Golden Crescent, is composed of Pakistan, Afghanistan and Iran, anf the final destination of the narcotic is Europe and the United States. The Golden Triangle is Southeast Asia, is composed of Burma, Thailand and Laos, and produces about one-third of the world's heroin. Although not a producer, the major transhipment and trafficing routes of the Golden Triangle are located in Malaysia. In 1984, this area had a bumper crop in that it was estimated that Burma produced 562.5 metric tons, Thailand produced 35.69 metric tons and Laos produced 70 metric tons (Drug Enforcement Agency, 1985).

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Because of its availability, heroin is relatively inexpensive, and a "bag" (100 mgs.) of heroin can be obtained for approximately $10. Furthermore, the purity of the heroin ranges from 40 to 80 percent and usually is Grade 3. Heroin in pure form, referred to as Grade 4, is a white powder with a bitter taste. However, its color can vary from white to dark brown because of impurities from the manufacturing process or the presence of various addictives. It is almost always injected. On the other hand, Grade 3 (brown in color) is smoked, with the abuser mixing heroin (spiking) with his/her tabacco. As indicated, the amount of heroin actually in a "bag" is quite high.

Although opium and its derivative (heroin) is the major drug problem in the area, cannabis or marihuana is also considered a problem. The cannabis plant grows abudantly (as it does throughout most of the world) in the region. In fact, the leaves of the plant, which contains little of the narcotic ingredient, THC, is used for cooking by a signficant proportion of the population in Southeast Asia.

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Treatment and Prevention

The seriousness of the drug problem in the region is most clearly represented by Malaysia. This multi-racial country, composed of 14.7 million, has the most well developed and intensive program of law enforcement, preventive education and rehabilitation among all the countries in Southeast Asia. On February 19, 1983, the Prime Minister declared the country's drug problem as a national emergency, and the government launched its massive campaign to eliminate this dadah (dangerous drugs) menance. Included in the governmental mandate, was the revision of the country's Dangerous Drug Act, in which the death penalty for trafficing was based on the amount of illict drugs confiscated. Specifically, this mandatory death penalty occurs if a person is apprehended with 15 grams of heroin or morphine; or 1,000 grams of opium (prepared or raw); or 200 grams of cannabis. Although all the other countries studied in the region have the death penalty, Malaysia is the only country with a specific weight requirement that pertains to presumption of trafficing. The number of drug abusers in the country, and specific characteristics of these abusers are included in Tables 1-4.

The role of public education with respect to drug abuse is widespread in the country, and ample use is made of the media. Concurrently, all the governmental Ministries are involved, and some of their activities have included the following:

1. Governmental personnel provided with in-service training on methods of disseminating information about drug abuse, including such in-service training for local community leaders.
2. Training courses for teachers (in-service or university level) on drug abuse and drug counseling.
3. Integration of drug preventive education subjects into secondary school curriculum.
4. Development of a semi-governmental organization, called Pemadam, that sponsors poster contests on drug abuse, vocational training programs, aftercare camps, religious counseling, films, recreational and other publicity activies focusing on preventing drug abuse.
5. Annual campaigns by such voluntary organizations as the Lions and Rotary Clubs, youth groups and religious organizations.
6. Training of youth leaders (within the schools) who are expected to impart their knowledge about drug abuse to their peers, as well as helping local authorities identify drug abuse in the schools.
7. Leadership camps for students awaiting the results of the educational examinations that qualify them for further secondary schooling, and for those students who have been identified as underachievers.
8. A voluntary program of registration, without loss of job, for governmental employees who are drug abusers.

Table 1

Demographic Characteristics of Malaysians

Detected for Illegal Drug Use, 1970-1985

YEAR	NUMBER	RACE %			SEX %		TYPE OF DRUG %			
		Malay	Chinese	Indian	Male	Female	Opium	Morphine	Heroin	Ganj
1970-75	12,468	58.4	19.8	19.1	91.6	2.4	6.3	16.6	78.3	4.7
1976	9,850	61.0	24.6	13.2	98.2	1.8	8.3	13.5	81.0	16.7
1977	8,047	49.7	30.8	16.8	97.7	2.3	6.9	8.1	88.4	8.8
1978	9,422	46.0	40.0	12.4	96.8	3.2	7.7	4.7	84.2	7.3
1979	8,299	41.4	42.7	14.6	97.1	2.9	8.5	5.1	81.2	9.3
1980	7,154	36.2	49.5	13.3	97.0	3.0	8.7	4.9	82.7	6.5
1981	10,391	44.7	40.6	12.4	97.3	2.7	5.3	5.9	82.6	12.6
1982	13,363	45.1	38.0	14.6	97.4	2.6	6.0	4.5	82.4	13.1
1983	14,624	48,2	37.1	13.1	98.5	1.5	7.2	6.4	77.4	12.8
1984	11,914	49.1	34.3	14.1	99.0	1.0	5.4	5.4	75.1	15.2
1985**	3,802	48.8	34.0	14.6	99.1	.9	5.2	5.4	75.2	15.2

N=108,207

Table 2

Number of Malysians Arrested Under New

Drug Law

SPECIFIC CHARGE	YEAR		
	1982	1983	1984
Section 38B (Trafficing)	260	363	462
Section 39A (Pushers)	332	255	120*
Other (Users)	9,808	10,263	5,622*
	N= 10,400	10,881	

* Jan - June 1984

Table 3

Prior Employment Status of 300 Inmates

at Pusat Serenti (1984)

WORK STATUS	PERCENTAGE
Unemployed	19.7 (N=59)
Unskilled	39.0 (N=117)
Semi-skilled	21.7 (N=65)
Skilled/Professional	19.6 (N=59)

Table 4

Summary Data of Malaysian Opiate Survey (N=150)

VARIABLE	NUMBER	%
AGE, 16-25 years	85	56.6
Cigarette Smoking	150	100
Underemployment	65	43.4
Education (Standard 1-Form 111)**	109	72.6
Family Size, 5-8 children	83	55.3
Birth Order (Eldest son)	51	34.0
One Parent Family	54	36.0
Type of Drug Dependence:		
Heroin	58	38.7
Heroin & Ganja	50	33.3
Multi-drug	32	21.3
Relapse (recividism)	135	90
Reason for relapse		
Fear of withdrawal	55	36.7
Peer Pressure	56	37.3

** 1st-9th grade

Similar to the highly developed preventive education program, Malaysia has one of the most comprehensive rehabilitation and treatment programs in the world. Specifically, rehabilitation involves both governmental and voluntary agencies. All of the six governmental rehabilitation centers in the country utilize "cold turkey" detoxification, and the treatment pocess is designed to reshape the individual in all areas of his life (all these facilities are for men). This process involves:

1. Physical restoration
   a. orientation and intake (detoxification is done prior to entry or at the facility)
   b. evaluation
   c. calisthenics, physical training and para-military drills.
2. Moral guidance and religious instruction
3. Vocational and recreational therapy
4. Psychological services, incl. individual, group and family counseling.
5. Review and discharge (compulsory two years in center)

Included in this rehabilitation system is the one-stop concept. This relatively new concept is that a one-stop center provides for all the necessary services from initial detection to eventual release. This means that as soon as a person has been identified as a drug abuser (urin test), he is brought to the center where a magistrate issues a detection order. If addicted to an opium derivative, detoxification begins. Another approach among these rehabilitation centers is the use of a work brigade, where inmates are made responsible for harvesting and the care of the country's palm oil trees. As stated all of these facilities are for men, and those few women identified as drug abusers are either sent to a prison, or given extended supervision (probation). All the service components of the rehabilitation centers are incorporated within a phase system in that an inmate can progress to a higher stage, with more responsibility and privileges, based on his performance.

The prisons in Malaysia also have a rehabilitation program whose services parallel those of the rehabilitation centers. However, unlike the centers, the length of treatment coincides with one's sentence. A person who is sentenced to prison, instead of being committed to a rehabilitation center, is someone whose drug related charge is other than usage, or although a drug abuser, has committed a serious crime.

For juveniles (under 21 years of age) who have committed crimes, their disposition is determined by a juvenile magistrate. Usually, first offenders whose crimes are not serious and have a family support system, are placed on extended supervision. If the juvenile is a management problem or has committed a serious crime, he/she is placed in a social welfare home. Again, those who also have drug related problems are placed in a segregated unit of the welfare home and undergo a similar rehabilitation program as discussed.

In order to treat th drug abuser, private agencies must have governmental approval and there are a variety of such agencies in the country, ranging from day programs to residential facilties. For the most part, these facilities are composed of those drug abusers who have volunteered for treatment, and are exempt from prosecution for drug usage. Although technically, such agencies can also serve those arrested drug abusers who were placed on extended supervision

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rather than being sent to a government center, this rarely occurs. Many of the voluntary agencies have a religious base and there is only one therapeutic community, modeled after Synannon, in the country.

Aftercare is required of all drug abusers, and one can be placed on a two or three year period of aftercare. During this time, the person must report to a local police station once a week where he/she may be given a random urine test and is required to attend weekly individual counseling sesssions. Although this is the most common type of aftercare, a person may also be sent to a residential or day care program. The decision as to what is the most appropriate type of aftercare is made by the magistrate in consultation with a governmental officer (probation).

Conclusion

The preventive and rehabilitative system for the drug abuser in Malaysia is the most comprehensive of all the countries studied (Refer to Appendix). This appears related to the seriousness of the problem in the country, and there is some indication that this concerted effort may be working. Although the study identified many patterns among the drug abuser in Malaysia, the only significant ones pertained to age, education and work status. However, when one examines all the countries studied, the only significant relationship is age. That is, it is more likely that a person identified as a drug abuser will be under 30 years of age. Nevertheless, there is evidence that there are many high risk factors associated with opium and cannabis abuse in Southeast Asia. Some of these involve poverty, high unemployment or underemployment, tabacco consumption, poor drug regulation and control, political instability, affluence, peer pressure, predisposition towards metaphysical or mystic experience, poor self concept, lack of information about the effects of drugs, family instability, societies in rapid transition (rural to urban), availability of drugs, and the occurrence of conduct disorders. Furthermore, the type of drug abused in a country is often related to the economic status of its inhabitants. That is, the small number of heroin users in the Phillipines may be related to the poverty status of many of its inhabitants. Therefore, it would appear futile to continue to search for such patterns, but instead, to suggest that drugs are viewed as "panaceas" or as a means in which individuals are able to fulfill unmet needs. However, what readily becomes apparent is that drug abuse can be curtailed by strong regulatory measures (decreasing availability), and an intensive national effort in the areas of law enforcement, preventive education and rehabilitation.

APPENDIX A

Summary of Drug Abuse and Treatment in
Singapore, Thailand, Indonesia, Phillipines

Singapore

In 1985, a report of the Home Affairs Ministry indicated that heroin was the primary drug the abuser (70.6%), with opium and ganja comprising 12.6% and 7.7% of the 4,000 persons arrested for illicit drug use. In addition, there appears to be a growing problem of inhalant abuse (glue sniffing) among young people and from 1980-1985, 1,627 cases (9.1%) of inhalant abuse were detected. Of this group, 88.7% were under 20 years of age.

The rehabilitation system in the country is administered by the Prisons Department, in that all arrested drug abusers are sentenced to one of the rehabilitation centers in the country. An unique aspect of this system is that those persons who "volunteer" for treatment also undergo the same programs as those who are committed by the courts. The rehabilitation system involves four centers for men, and an unit in a female prison for women. The treatment process involves the following five stages:

1. One week orientation and cold turkey detoxification is used, unless the inmate is 55 years of age or above or has medical complications, in shich case, withdrawal is gradual with the use of tranquillizers.

2. One week period of recuperation and recovery.

3. One week period of intensive indoctrination, consisting of discussions of the evils of drug abuse, and the negative effects of drug use on the well being of the nation.

4. Thirteen weeks of military training in order to instill a sense of discipline and the importance of physical fitness.

5. Three months to two years, where the inmate maintains a 44 hour week at an industrial workshop. These workshops are linked with the private sector, in that both the equipment and vocational training are provided by employers.

Once deemed rehabilitated, an inmate can be released outright into supervison (probationary period) or sent to a Day Release Camp. The Day Release Camps are similar to half-way houses in that they help the former abuser with community integration. While at these Camps. the individual maintains a full time job, and is given an urine test every evening. If the test is positive, the resident can be sent back to the rehabilitation center or to a magistrate for sentencing on criminal charges. Lastly, the residents can avail themselves to counseling services, and can earn week-end passes.. For those persons released outright from a rehabilitation center or who finish their six months at a Day Camp, are supervised for a period of two years by officers of the governmental Central Narcotics Bureau (CNB).

Singapore enacted the death penalty for trafficing in 1975, at which time, the government, declared a national emergency and launched the Ferret operation. Since 1978, there has been a gradual decline in the number of detected (volunteers or those arrested) drug abusers (i.e., 7,000 arrested in 1980 and 4,000 in 1981).

Thailand

In 1984, there was reported to be an estimate 60,000 drug addicts in Thailand, with the most vulnerable group being students (poly-drug use), urban youth, and the hill tribes of the country. The drug problem is complicated by the fact that the opium poppy and cannabis are grown in the hill regions of the country, and that opium smoking was only made illegal in 1958. In fact, it was reported that there were 70,985 registered opium addicts in Thailand in 1959 (Poshyachindal, 1984).

The types of treatment can be classified as in-patient, out-patient or traditional. In-patient treatment involves a 10-14 day period of detoxification, followed by a program of psychological, occupational therapy, and vocational training (carpentry) and religious instruction. Out-patient treatment involves a period of detoxification in which addicts receive daily dosages of methadone for a period of 21 days. These individuals are then placed on various schedules of reducing methadone dosages, and if they so desire, can make use of the psychological services at the clinic. Basically, this program can be viewed as a period of initial methadone maintainance, followed by a gradual from of detoxification. If the person becomes re-addicted, he/she must wait for a specific period of time before readmission to the clinic. Traditional form of treatment primarily involves herbal and spiritual therapy. Such therapy is conducted in the various Budhist temples in the country, and usually combines herbal medication that induces severe vomitting with a religious vow of abstinence. Althoug extensive use is made of hydrotherapy, occupational therapy and vocational training (usually tailoring), the emphasis is placed on a spirtual re-birth of the drug addict. In fact, one Budhist temple does not use herbal medication, but require their residents to attend their own mocked funeral and to celebrate their re-birth. Furthermore, in those temples where only herbal medicine is used, various forms of physical exercise are encouraged, and the residents can enter the priesthood after a period of time that that demonstrates sincerity. The recipes of herbal medicine are not known outside of the temple, and their effects can range from inducing vomitting to inducing a state of semiconsciousness, unconsciousness or delirium.

Although not really rehabilitation, the Thai government has a program of opium detoxification for the hill tribe people. This program has no supportive services, and consists only of detoxification with the use of tranquillizers.

The problem of drug abuse in Thailand appears to have remained stable since opium was made illegal. As stated it is complicated in part by the long history of opium consumption, dating back to the reign of King Ramathibodi 1 in 1360. The hill tribe (mountain people), with their long history and traditions surrounding opium consumption, are the major growers of opium in the country. Although there has been recent attempts at the use of crop substitution (kidney beans and coffee) by the government, it does not appear to have been successful in curbing the illegal opium crop. The country has a death penalty for trafficing (production/importation of heroin for sale or distribution).

Indonesia

Of the 126 million Indonesians, there were 70,000 drug abusers in 1985. As in most Asian countries, opium smoking was legal til the end of World War 11, and the country's drug problem is identified with its youth. The drug treatment program is governmental and voluntary, and consists of rehabilitation centers, private mental hospitals, residential facilities, and the prisons.

The rehabilitation process in general involves intake and information to

the parents of the drug abuser, physical and psychiatric examinations, detoxification (cold turkey or gradual with use of tranquillizers), and post-withdrawal treatment which involves individual, group and family counseling, recreational therapy, fitness, relaxation training, language courses, art and music sessions. Commitment to these centers is usually for two years.

If the drug abuser is a juvenile offender, he/she can be sent to a correctional center, and the major components of treatment consists of the use of cold turkey detoxification, and a variety of work related vocational training programs (sewing, hair dresssing, carpentry and photography). The center usually has a maximum length of stay of five months, and admission is usually determined by parental request.

The Indonesia problem with respect to drug abuse is unclear, primarily due to the government's reluctance to provide information. The country is a Islamic nation, and thus the major form of abuse involves cannabis and the opium derivatives. Indonesia also has a death penalty for trafficing (by firing squad). Lastly, the emphasis on youth and family involvement is an important component of all the rehabilitation programs.

Phillipines

At the time of this investigation, the government of the Phillipines did not feel that the country had a drug problem. Unlike the other countries discussed, there does not appear to be a problem with Opium derivatives, and the primary drugs of abuse are alcohol and glue snifffing. In 1985, it was reported (San Pedro, 1985) that the country only had 8,000 heroin addicts.

The country only has one governmental rehabilitation facility, and this is the National Bureau of Investigation, Treatment and Rehabilitation Center. Admission is voluntary or by court referral, and the goals are to motive the addict to extramural living, resocialization and vocational training. The male residents, 13 to 40 years of age, are required to attend weekly group sessions and monthly family sessions. These therapeutic encounters are always led by a psychiatrist. The resident can involve himself in such crafts as carpentry, silk screening, wood laminating, painting, shingle making and metal etching, There is also an in-house educational program, and discharge is based on the evaluation of the treatment team.

Among the non-governmental facilities, there are residential treatment facilities (half-way houses), conservation programs (work camps), and religious training. One such facility, conducted by a Catholic priest, uses the technique of primal therapy---residents provided with relaxation training that is followed by having them concentrate on thoughts about their early childhood and then asking them to "scream" their past hurts and feelings. Another facility in the country is modelled after Synannon and only employs ex-addicts.

Aftercare, which is not mandatory, includes out-patient counseling, periodic follow-up visits by social workers, and the use of transitional living settings, such as half-way houses.

Phillipines also has a death penalty for trafficing, and its treatment focus is placed on the nation's youth. The country's drug laws provide exemption from prosecution if a person voluntary submits him/her self to treatment and rehabilitation. However, these drug laws do not however pertain to persons arrested for drug abuse.